WHO DELIVERS PRIMARY CARE?*

NORA PIORE

Associate Director, Center for Community Health Systems

Professor of Public Health (Economics)
Columbia University School of Public Health

New York, N. Y.

IT HAS BECOME a tradition that what goes on the program of this Annual Health Conference also determines what goes on the research agenda of New York City. Over the years the planners of this conference have demonstrated a talent not merely for putting their fingers on crucial and timely issues, but also for finding and bringing together the people who are thinking about things in a new way or who have some important, interesting, or promising alternative—either on the drawing board or in operation—that is relevant to the problems of health services of New York City.

The models for primary care presented this morning all sound good—feasible, reasonable, modest in their claims, demonstrably able to recruit and retain staff, and demonstrably able to find a market, enroll a population of subscribers, or develop a medical practice which is large and stable enough to support that staff. But if that is all, I have to ask "so what?" After all, in this building and for this audience, group practice, health maintenance organizations, and neighborhood health centers are all ideas whose time has long since come.

Two things make this morning's session different and important. One is the fiscal crisis New York City is experiencing. We have moved into a time of consciousness of scarcity. We have become aware that health resources are finite and cannot be expected to increase. Following so closely on the decade of the 1960s, when resources seemed limitless and research seemed always to be innovative in a climate of expanding resources, the present challenge is of a different kind. Today, we must look at these models of health-care organization for clues as to how the city can do more for less.

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The other important aspect of this session is represented by Dr. Michael M. Stewart's paper, signifying recognition that, for the moment at least, the hospital outpatient department is here to stay—that it is where the action is. It provides the realistic opportunity to adapt the various models of good primary-care organization to serve large masses of people.

It would have been even better if we could have had one more speaker this morning, someone from one of the 350 "Medicaid mills" in the city or one of the 800 or so office-based practitioners who together account for two thirds of the sum paid by Medicaid to physicians for the care of patients.

No one knows exactly how many ambulatory visits are made in New York City each year. If nationwide averages apply, the total is about 40 million. Thirteen million visits are made to hospital clinics and emergency rooms each year at a cost that may be as high as $30 million. This means that each day 100,000 persons cross hospital thresholds in search of medical care. We do not know precisely how many visits are made to doctors' offices by the Medicaid population; a reasonable estimate is an additional six million visits.

For those concerned with New York City, the question implicit in this morning's program is how the benefits of the primary-care models described can be related to these two large segments of the city's population and whether the hospitals of the city can provide the leadership and manpower needed to bring this about, either on the hospital premises or in off-site locations affiliated or under contract with the hospital.

Two basic questions can be raised. They require research, and should be answered. The first has to do with districting or enrolling that part of the population whose care is paid for out of public funds.

The models described this morning all share one essential characteristic—a *sine qua non* of group-practice, neighborhood-health-center, or hospital-based primary-care models. Each medical-care system permits the orderly allocation of finite known resources to meet the predictable needs of a known population.

In the absence of these components—a known population with statistically predictable needs, finite but identified resources, and the organizational and management structure that permits the allocation of these resources according to orderly priorities—it is difficult to see how the benefits of a planned system can be realized.

To achieve the benefits of these primary-care models for large segments

of the population it is necessary to determine to what extent the population in this city can be expected or induced to follow some orderly process in using medical-care services. This is not a new question, but we still do not have good answers. To begin with, we lack necessary information about the existing pattern of use in the city. The raw data needed to develop such information is or soon will be available. Miscellaneous pieces of data could be stitched together to provide more systematic information. Before long Medicaid should be able to furnish utilization patterns for its population, and the present analysis Blue Cross is making of hospital outpatient utilization will contribute an important component. When all the available information is put together systematic patterns of use may emerge. If this basically is the case, mechanisms can be used to strengthen further the orderly character of the pattern. Recall how simply and well the old system of referring newborn infants worked; a postcard would go from the maternity hospital to the well-baby station nearest the home of the mother. This was followed by a postcard from the well-baby station to the mother, setting an appointment for a six weeks checkup for the baby at the child health station, with arrangements for followup of missed appointments. This simple system succeeded in establishing a direct relation between infant and health center. Many opportunities exist to use this kind of mechanism, especially for young families with children and for the elderly who receive Medicare. For each new school entrant an interview with a parent and school representative customarily is scheduled. During this interview parents could be advised of alternative child-health facilities and arrangements could be developed for referral. It would be within the statutory framework of the Medicaid program to offer enrollees several choices of providers; whether it would be desirable to do so should be explored. At this moment no one knows how the pluses and minuses of such an arrangement would balance out, but this is an essential area of research related to the central question of how model practices in primary care can be adapted to serve the larger population groups in New York City.

A second urgent area for research has to do with a comparison of the cost—per visit and per episode of illness—of providing primary-care services in physicians' offices and in ambulatory-care facilities of community hospitals.

Large sums of federal, state, and city money are now spent for care in hospital clinics and emergency rooms. Provision of general medical services and primary ambulatory care to self-referred patients in hospital

clinics and emergency rooms is widely believed to be more costly than equivalent services that could be obtained in private physicians' offices or free-standing clinics.

Serious questions are being raised concerning both the suitability and the economic viability of providing primary care in hospital settings. The development of alternative methods for providing primary care crucially hinges on comparative cost data which are not now available.

Assuming that out-of-hospital alternatives could be made available and accessible to the population that presently visits clinics even if fees were set high enough to be an inducement to physicians, it becomes most important to analyze the cost of existing hospital ambulatory services to determine whether such services could be produced at lower cost by office practitioners.

In considering these comparative costs it is necessary to view the issues from both a micro and macro perspective, comparing not only the relative cost of a particular procedure in one or another setting, but also the effect on total community ambulatory costs. The effect on the unit cost of residual services, those services which would need to remain in a hospital setting, that would result from separating out the less costly procedures, should not be overlooked. That a solo practitioner, like a small firm, can handle certain procedures more efficiently or cheaply than a hospital or a large clinic—just as proprietary hospitals which provide only routine operations such as tonsilectomies and appendectomies and do not offer services requiring infrequently used, expensive equipment and staff can perform these services at lower costs than larger and more complex institutions—seems a logical assumption. But the complex procedures may become even more costly per unit when the simpler procedures are creamed off.

It also is possible that the cost of a visit would be higher in the hospital than in the physician's office because of the content of treatment—more tests, consultations, and return visits. On the other hand, the office physician might have a fiscal incentive to require return visits that would be absent in the case of salaried hospital staff. The office visit also could be less costly because the doctor might be familiar with the patient's history and personality, while the hospital personnel might not. In the hospital, records would have to be consulted, past history obtained, and tests ordered because the physician had no experience with the patient on which to rely, whereas the office practitioner might have all this in his head. However, the personnel in a hospital or large clinic might have broader

knowledge of current epidemiology, enabling them to make a more informed diagnosis.

We need much more than a re-examination of the economies and diseconomies of scale in the provision of medical care. We need research to provide a basis for two kinds of decisions: 1) Assuming that this would bring about a desirable quality of care, at what price per visit would it be economical to try to persuade more office practitioners to enter the Medicaid market? 2) If it seems unlikely that reasonable increases in fees for physicians' visits would increase the supply of quality private-office care, then in what ways could the performance of primary-care services within the hospital or under hospital supervision be organized to take advantage of the more economical patterns that are characteristic of physicians' office services?

Perhaps I have gone the long way around to get to the point. If the benefits of the primary-care models so attractively presented by our panelists this morning are to become widely available, it is likely to be because Dr. Stewart and others coping with reorganization and redesign of hospital-based ambulatory services will succeed in incorporating the positive features of group practices and neighborhood health centers into a hospital ambulatory-care scenario—whether on the hospital site but administratively separated with a contractual relation to the hospital or offsite with the hospital serving as the base. However the scenario is to be written, we need more scripts submitted for review.